DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Surveyor: 29354 An onsite revisit survey was conducted on 11/15/21 through 11/16/21 for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, for all previous deficiencies cited on 9/30/21. Avantara Norton was found not in compliance with the following requirements: F609, F610, F684, F686, and F842.	{F 000}		
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	{F 609}	F 609 1.No immediate correction could be made for delay in notifying SD Department of Health (SD DOH) for resident 1's reportable incident. SD Department of Health initial and final report was submitted on 11/22/21 and accepted on 11/23/21. 2. All residents are at risk of reportable incidents not being reported to SD Department of Health. 3. Clinical leadership was educated on completing a thorough investigation, what should be reported, process for reporting, and timely reporting reportable incidents to SD DOH on 11/22/21 by Corporate Regulatory Specialist. 4. The DON or designee will audit all incidents to ensure they were thoroughly investigated, and if appropriate, reported to SD DOH within the required reporting time frame. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Quality Manager at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	12/14/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Hubbeling — TITLE: Interim Administrator — (X6) DATE: 12/10/2021

RECEIVED
DEC 17 2021
SD DOH-OLC

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 609}	Continued From page 1	{F 609}		

incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Surveyor: 29354
Based on closed record review, interview, and policy review, the provider failed to ensure the South Dakota Department of Health (SD DOH) had been notified of a reportable incident for one of one sampled closed record (1). Findings include:

1. Review of an anonymous concern received by the SD DOH on 10/29/21 regarding resident 1 revealed:
*On 9/10/21 she had:
-Been transported by a wheelchair agency to a physician's clinic.
-Received a COVID-19 vaccine at the physician's office.
--It had been the wrong physician's clinic.
*The provider had not reported the above anonymous concern to the SD DOH.

Interview on 11/16/21 at 9:12 a.m. with director of nursing (DON) B regarding the 10/29/21 anonymous concern about resident 1 revealed:
*She had cognitive impairment..
*Her daughter usually took her to appointments.
*She had gone to the wrong physician's clinic and had received a COVID-19 vaccine.
*Her initial thought was the incident was reportable to the SD DOH.
*Their process for determining if an event was reportable was to contact corporate nurse consultant H and regional director of operations DD.
-They did not think it was a reportable event.
*She had visited with the SD DOH complaint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 609}	Continued From page 2	{F 609}		

department and she was informed they should have reported it.
*Before an event was reported to the SD DOH it was reviewed by upper management and they would make the final decision.
*She had visited with the ombudsman regarding the event, and he had said "when in doubt report."
*They had changed their process on how they sent residents out to appointments.
*They had educated the staff.
*They did not have a formal policy for sending residents to appointments, just a process.
*They:
-Had stand-up meetings every day at 9:00 a.m. to go over resident records and the resident appointments.
-Decided which resident's were cognitively impaired.
-Decided which resident required to have a staff member with them for their appointments.
*There was no documentation agency registered nurse (RN) FF or agency licensed practical nurse (LPN) GG had received education on the new process of sending residents to appointments.
*They had not educated the agency staff on the new process.
*There was no documentation in the agency staffs resource binder on how to handle residents going out on appointments.
*She had done a poor job documenting the event and the follow-up with each physician's office.
*The following agency staff and hire dates were:
-RN FF: 10/27/21.
-LPN GG: 11/4/21.

Interview on 11/16/21 at 11:05 a.m. with corporate nurse consultant H and regional director of operations DD regarding the 9/10/21 event with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 609}	Continued From page 3 resident 1 revealed: *The event had not been reported to the SD DOH. *Corporate nurse consultant H had visited with her boss who was vice president of clinical operations EE regarding the 9/10/21 event. --Vice president of clinical operations EE said since there was no adverse reaction it did not need to be reported. -DON B had done some follow-up investigation on the 9/10/21 event. *Regional director of operations DD: -Questioned if the receiving unit had not taken responsibility for the event. -Thought in hindsight it was a good thing to over report. *The staff agency should have been oriented on their new process for residents going out on appointments. -They had recently started using agency staff. -Agreed there was no documentation in resident 1's medical record regarding the 9/10/21 event. *The administrator was not in the building during the survey time frame. Review of the internal investigation completed by DON B regarding the 9/10/21 event with resident 1 revealed: *"On 9/10/21 around 10:00 a.m. they discovered resident 1 had been mistakenly picked up by transport vendor for a COVID-19 vaccine appointment at [name of facility]." *Another resident was to have gone to that appointment. *Resident 1 had received a third COVID-19 vaccine. -Her daughter and personal care provider (PCP) were notified of the medication variance. -The facility where she had received the	{F 609}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 609}	Continued From page 4 COVID-19 vaccine had been notified. *They started educating the staff on sending a residents' face sheet with their picture to all their appointments and verifying the resident picture on the face sheet matched the resident going to the appointment. *DON B had received a return telephone call from resident 1's PCP and stated "COVID vaccine administration is fine." Review of resident 1's medical record revealed: *An admission date of 9/7/21. *Diagnoses of depression, anxiety, dementia, and mild cognitive impairment. *The 9/13/21 Minimum Data Set assessment documented: -Her Brief Interview for Mental Status examination score was 8 indicating she was cognitively impaired. -She required extensive assistance of one staff for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. *The 9/7/21 through 9/25/21 progress notes had not included any documentation on the 9/10/21 event. Review of the provider's May 2019 Abuse and Neglect policy revealed: *"Reporting: -All allegations and/or suspicions of abuse/neglect must be immediately reported to the facility Administrator or designee in the absence of the administrator. -Failure of an employee to report an allegation and/or suspicion of abuse will result in disciplinary action. -The Administrator is the Abuse Coordinator. -Preliminary Investigation Report: The abuse coordinator must submit a preliminary	{F 609}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 609}	Continued From page 5 investigation report to their required state agency immediately once assurances for the resident's or other resident's safety have been established. -Final Investigation Report: The abuse coordinator must submit a final investigation report to their state agency within five (5) working days of the allegation." *The policy had not included contacting corporate nurse consultant H, regional director of operations DD, or vice president of clinical operations prior to submitting a report. Refer to 610, findings 1, 2, 3, 4, 5, 6, and 7. Surveyor: 43844 Surveyor: 45383	{F 609}		
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610	F 610 1.Immediate verbal education was given to all nurses in the building on 11/16/21 by the DON on the process for resident appointments. 2. All residents are at risk for potential harm relating to lack of education to both facility staff, agency staff, as well as outside agencies. Updated the process regarding residents leaving the facility for appointments on 11/23/2021. Updated process includes the need to review BIMs score prior to sending residents out for appointments. Process was placed in Nurse resource book on 11/23/2021. Process was also placed in orientation binder for new employees as well as agency employees on 11/23/21. 3. RN/LPN staff were educated on process and where to find it on 11/23/21 and 11/24/21 by the DON. Outside agencies were provided education of this process on 12/8/2021 by DON. Education will be provided by the DON regarding this process at the "All Staff" meeting on 12/14/21.	12/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 6 by: Surveyor: 29354 Based on observation, interview, and closed record review, the provider failed to provide education to two of two agency staff registered nurse (RN) (FF) and licensed practical nurse (LPN) (GG) following a reportable incident to the South Dakota Department of Health (SD DOH). Findings include: 1. Review of the internal investigation completed by director of nursing (DON) B regarding the 9/10/21 event about resident 1 revealed: *"On 9/10/21 around 10:00 a.m. they discovered resident 1 had been mistakenly picked up by transport vendor for a COVID-19 vaccine appointment at [name of facility]." *Another resident was to have gone to that appointment. *Resident 1 had received a third COVID-19 vaccine. *They started educating the staff on sending a residents' face sheet with their picture to all their appointments and verifying the resident picture on the face sheet matched the resident going to the appointment. 2. Interview on 11/16/21 at 7:35 a.m. in the Warren/Rehab Wing with LPN GG regarding residents going to appointments revealed: *She was an agency nurse and had been employed on 11/4/21. *Resident 5 had an appointment. -His paperwork had not included a picture on his face sheet. -She had gone to the electronic medical record and stated he requested no picture be taken of him. -She would verify who the resident was by asking	F 610	Continued from page 6: Education will include the process to ensure residents in the facility who are attending outside appointments or events have appropriate identification and paperwork whether being accompanied by staff or planned to meet up with family on the receiving end. Any staff that missed the education will be educated prior to their next shift worked. 4. DON or designee will audit to ensure policy was followed for 3 resident appointments. Audits will be weekly for four weekly, then monthly for two months. Results of audits will be discussed by the Administrator at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on their findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 7	F 610		

the resident their name, date of birth , why they were going to the appointment, and then check the appointment book.
*She had not received any training on the new process for sending residents to appointments.
*She was not aware of sending photos with residents to their appointments.

3. Interview on 11/16/21 at 7:45 a.m. with RN FF in the Central Wing regarding residents going to appointments revealed:
*She was an agency nurse.
*Resident 6 had an appointment.
*The overnight nurse got the "packets" ready to send with the residents for their appointments.
*She had been told to send the face sheet and the medication administration record with the resident.
*She would verify the residents date of birth prior to having them leave for an appointment.
*If she had questions, she would ask the other nurse or the DON.
*She had not received any training on the new process for sending residents to appointment.

4. Observation and interview on 11/16/21 at 8:05 a.m. with LPN GG regarding residents going to appointments revealed:
*She had a bracelet with resident 5's name on it.
-The bracelet included his date of birth, admission date, and physician's name.
*She had just visited with DON B regarding the new process for residents going to appointments.
*Prior to that she did not know the new process for residents going to appointments.

5. Interview on 11/16/21 at 9:12 a.m. with DON B regarding the new process for residents going out on appointments revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 8 *They had changed their process on how they sent residents out to appointments. *They had educated the staff on residents going to appointments. *They did not have a formal policy for sending residents to appointments, just a process. *They had stand-up meetings every day at 9:00 a.m. to go over resident records, decided who was cognitively impaired, and if they needed to send a staff member with. *They had not educated the agency staff on the new process for sending residents to appointments. *There was no documentation in the agency staffs resource binder on how to handle residents going out on appointments. *The following agency staff and hire dates were: -Registered nurse FF on 10/27/21. -Licensed practical nurse GG on 11/4/21. 6. Interview on 11/16/21 at 11:05 a.m. with corporate nurse consultant H and regional director of operations DD regarding the 9/10/21 event with resident 1 revealed the agency staff should have been oriented on their new process for residents going out on appointments. 7. Review of the provider's new process for Resident Identification for Appointments revealed: *"When a resident leaves the facility for ANY and ALL types of appointments, the procedure is as follows: -Resident's face sheet/admission record must be sent with the resident. -Facility staff must physically look at the picture on the resident's admission record to verify they are sending the correct resident to the appointment. -Facility staff must have the transportation driver	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 9 state the resident they are transporting to ensure it matches the face sheet. -If a resident is verbal, staff are also to ask the resident their name and have the resident state their name to the staff member prior to going with the transportation vendor to the appointment. -All appointments must be written in the appointment book immediately upon booking the appointment or receiving appointment details from the provider." *It had not included: -What to do for residents who refused to have their picture taken. -What was the process for cognitively impaired residents. -The use of the identification bracelets. Refer to 609, finding 1.	F 610		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on closed record review, interview, document review, policy review, and information submitted to the South Dakota Department of Health (SD DOH), the provider failed to ensure one of one sampled resident closed record (107)	F 684	F 684 1.No immediate correction could be made for resident 107 not having her decline in health documented, her physician's orders for her to be weighed weekly followed, her physician's orders for reporting blood pressure followed, and her care plan reviewed and updated to reflect her current needs. 2. All residents are at risk for not receiving quality of care in accordance with professional standards of practice. 3. Education will be done at the "All Staff" meeting on 12/14/2021. Education will be done by the DON and will include documentation of residents' decline, physician orders (noted were weekly weights and blood pressure reporting) are acknowledged and followed and if not understood or questioned, documented communication with the physician occur.	12/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 had: *Her decline in health documented. *Her physician's orders for her to be weighed weekly followed. *Her physician's orders for reporting her blood pressure reading followed. *Her care plan reviewed and updated to reflect her current needs. Findings include: 1. Review of [name of facility] Healthcare Online Self-Reporting received by the SD DOH on 10/5/21 regarding resident 107 revealed: *On 10/5/21 at 10:00 a.m. resident 107's daughter had requested to speak to a nurse manager. *At 10:10 a.m. the director of nursing (DON), assistant DON, and social services went to her room to speak with the family. *The family reported she had been laying in urine for hours. -Her brief was wet at that time. -Staff had "offered to give care immediately and change brief, family refused." *Certified nursing assistant (CNA) was suspended pending investigation. *Follow up: -"Family refused to allow staff to help with any further cares and took resident home AMA (against medical advice) at 11:05 [a.m.]. Family refused skin assessment. Resident had been previously changed at 9:30 [a.m.]on] 10/05/2021. This is verified by 3 seperate staff interviews." 2. Review of an anonymous concern received by the SD DOH on 10/6/21 regarding resident 107 revealed the alleged concern was the nursing staff had failed to care for her.	F 684	Continued from page 10: Education will also be done to ensure the care plans reflect an accurate picture of resident care needs. All licensed and unlicensed staff will be educated about their roles and responsibilities with the identified areas. Any staff that missed the education will be educated prior to their next shift worked. 4. DON or designee will audit 4 resident charts to ensure weights and blood pressures are being completed per physician orders, decline or change in condition is documented, care plan reflects current needs, and communication with physician is documented. Audits will be weekly for 4 weeks, then monthly for 2 months. Results of audits will be discussed by the Quality Manager at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on their findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 3. Review of documents provided to the SD DOH prior to the 11/16/21 onsite revisit survey regarding resident 107 revealed: *She had been admitted to [name of hospital] from 9/6/21 through 9/13/21. -Diagnoses was T4 compression fracture and found to be underweight. *She had been admitted to [name of long term care facility] on 9/13/21. *On 10/5/21 her family had removed her from [name of long term care facility] after they found her sitting in her urine and feces, apparently dehydrated, hypoxic, and having lost a significant amount of weight. *They had left AMA from the facility. *She was brought to [name of clinic] by her family. -The clinic recommended they take her to the emergency department (ED) due to dehydration, failure to thrive and worsening from baseline. *On presentation to the ED she was tachycardic, normotensive [normal blood pressure], hypoxic requiring 4 liters of oxygen. -She had required 1 to 2 liters of oxygen at baseline. *She was admitted to [name of hospital] on 10/5/21. *She was COVID positive prior to admission. -She was treated with steroids and Remdesivir during her hospitalization because of increased oxygen needs. *The wound team had been consulted. -She was assessed to have a "stage deep tissue injury ulcer on her left sacral area, her right heel, and the right buttock area." --"Pain from these improved with regular repositioning and topical cares." *The nutrition team evaluated her becaus she was severely underweight.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 -On 10/6/21 her weight was 69 pounds 4.8 ounces. -"They diagnosed her with severe protein-calorie malnutrition at that time and gave her diet recommendations." -She was able to eat and drink in small amounts during her stay. -She had lost eleven pounds in three weeks. *The palliative team "was consulted to discuss pain management, code status, and potential need for hospice referral based on [name of resident] status. They met with the family on 10/9 [21] following permission from [name of resident] daughter." -Resident voiced she did not want cardiopulmonary resuscitation, intubation, or feeding tubes. -Her code status was changed to do not resuscitate. -She did not want further admission to the hospital. -She did not voice interest in hospice. -She did not "participate in physical therapy evaluations so there was not a placement recommendation." -During her stay she required two-person assistance for the majority of her needs. --She remained in bed during her stay. *After discussing her care needs with her family members, they opted to take her home to care for her with home health referrals. *She was discharged on 10/13/21 to her family in fair condition with home health services. -Her diet on discharge was a gastric bypass diet. -Her activity on discharge was limited mobility requiring two people for assistance. *On 10/15/21 her problem list was reviewed by physician HH. It included: -Diagnoses of anxiety, back pain, Barrett's	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13 esophagus with esophagitis, carotid artery stenosis, chronic neck pain, compression fractur of T4 vertebra noted on 9/13/21, COPD with exacerbation noted on 7/7/21, depression, degenerative joint disease, elevated troponin noted on 10/15/21, encounter for monitoring opioid maintenance therapy noted on 9/13/21, failure to thrive in adult noted on 10/5/21, fibromyalgia, GERD, hypertension, pressure injury of deep tissue of sacral region, PVD, severe malnutrition noted on 10/5/21, short of breath, underweight noted on 9/13/21, and Vitamin D deficiency. *On 10/5/21 both [name of clinic] and [name of hospital] records documented a sacral pressure ulcer and failure to thrive. 4. Review of resident 107's closed medical record from [name of long term care facility] revealed: *Admitted on 9/13/21 to the Warren/Rehab Unit. *Multiple diagnoses of wedge compression fracture of fourth thoracic vertebra, unsteadiness of feet, low back pain, weakness, anxiety, esophagitis, chronic pain, COPD with acute exacerbation, depression, diverticulitis, fibromyalgia, hypertension, shortness of breath, and vitamin D deficiency. *Physician's orders for: -Regular diet, thin liquids consistency. -May follow registered dietitian recommendations. -Ensure three times a day for supplement. Record percentage consumed. -Weekly weight. -Physical therapy and occupational therapy to evaluate and treat. -Report systolic blood pressure over 150 one time a day related to primary hypertension. *She was diagnosed with COVID-19 on 9/23/21 and transferred to the COVID-19 unit.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 14 *She was moved to the Warren/Rehab Wing on 10/3/21 and remained in isolation. Review of the 9/16/21 admission/5 day Medicare Minimum Data Set (MDS) assessment revealed: *Her Brief Interview for Mental Status examination score was twelve indicating she was cognitive. *She required extensive assistance of one staff for bed mobility, transfers, locomotion, dressing, toileting use, personal hygiene, and bathing. *She had not ambulated. *She was independent with eating after set-up assistance. *She was coded as "no" for being at risk for developing pressure ulcers/injuries. -There were no skin issues. -Treatment was pressure reducing device for chair and bed. -She was not on a turn/repositioning or hydration/nutrition program. *She was 62 inches tall, and weight was 80 pounds. -She did not have any eating issues. -She was not on a therapeutic diet. *She was always continent of bowel and bladder. Review of the 9/13/21 admission initial skin assessment completed by agency licensed practical nurse (LPN) MM for resident 107 revealed: *She did not have any skin issues. *There had not been any further skin assessments completed. Review of the following Braden Scale and Clinical Evaluations assessment completed for resident 107 revealed on: *9/13/21 her score was thirteen.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15	F 684		

-A score of thirteen to fourteen was moderate risk.
*9/20/21 her score was nineteen.
-A score of fifteen to eighteen was mild risk.
*There had not been any further Braden Scale and Clinical Evaluation assessments completed for her.

Review of the nursing UDS [daily assessment] from 9/13/21 through 10/4/21 had not indicated any skin issues.

Interview on 11/16/21 at 1:40 p.m. with DON B regarding the skin assessment revealed:
*She would have expected the skin assessment to be done with her clothes off.
*They were unable to contact agency staff LPN MM because she had not worked at the agency and she was not returning a call to the facility.

Review of resident 107's weight history and review of 9/13/21 through 10/4/21 medication administration record (MAR) revealed:
*On the following dates her weights were:
-9/13/21: 80 pounds.
-9/25/21: 78 pounds.
--That was a 2.5% weight loss in twelve days.
-No further weights had been documented at the facility.
*The hospital documented her admit weight on 10/6/21 as 69 pounds.
-That was a 13.75% weight loss in twenty-two days.

Review of 9/13/21 through 10/4/21 MAR and physician's orders for resident 107 revealed:
*The 9/14/21 physician's order was to:
-Increase lisinopril to 20 milligrams (mg) oral every day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16 -Give an extra dose of lisinopril10 mg orally one time now. -Check vital signs every hour times four hours, report if systolic blood pressure was greater than 150. *There was no documentation her blood pressure had been checked every hour times four hours. *The 9/15/21 physician's order was to: -Do vital signs daily, report systolic blood pressure greater than 150. -Increase lisinopril to 30 mg oral every day. *Her systolic blood pressure had been documented twice on 9/16/21 as 172 and 196. *There was no documentation the physician had been notified on 9/16/21 her systolic blood pressure had been greater than 150 twice. Review of the 9/16/21 registered dietitian dietary evaluation for resident 107 revealed: *Her most recent weight was 80 pounds on 9/13/21. *She "leaves behind a significant proportion of meals, snacks, and supplements daily for even a few days. *Intake less than 25% of meal. *Overall intake of fluids was less than 1000 milliliters per day. *Ensure three times a day. Review of the following occupational therapy (OT) notes regarding resident 107 revealed on: *9/14/21 she began occupational therapy. *9/29/21: progress "Notable setbacks in progress towards STGs (short term goals) due to recent COVID-19 Diagnosis. Anticipate gains within reasonable period of time." 10/7/21: They had provided skilled treatment interventions that included "instructing and training patient [resident] in proper body	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17	F 684		

mechanics and safe transfer techniques.
-They were working with her for urinary incontinence.
-She had left the facility AMA.
-Discharge recommendations: "Requires skilled nursing and therapy cares in order to return to PLOF (previous level of function)."
*She had multiple times of refusing to participate in OT and physical therapy (PT).

Review of resident 107's undated MDS Kardex Report for [name of facility] - SNF (skilled nursing facility) revealed:
*Her short term memory was ok.
*She was independent in daily decision making.
*Speech was clear.
*Able to understand others and make herself understood.
*Required set-up help with eating.
*Was frequently incontinent of bowel and bladder.
*Had a pressure reducing device for her chair and the bed.
*Was not marked for being on a turning/repositioning program, nutrition or hydration interventions, or ulcer care.
*Was not marked for nutritional problems for weight loss, fluid management, or intake and output.

Review of resident 107's care plan with the following date focused areas were initiated revealed:
*9/15/21: "Is at risk for alterations of bowel and bladder functioning related to: Need for extensive assist with toileting."
-Interventions included monitor for pain/discomfort due to catheter use and remind, offer and assist with toileting as needed.
--There was no physician's order or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18	F 684		

documentation she had a catheter.
*9/15/21: "Resident has potential for skin impairment."
-Interventions included assess for pain, encourage good nutrition and hydration in order to promote healthier skin, keep skin clean and dry. Use lotion on dry skin. Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to MD. Turn and reposition as needed."
*9/15/21: "Is at risk for altered cardiovascular functioning related to: Hypertension."
-Interventions included monitor vital signs as ordered. Report to MD for any changes. Obtain labs and weights as ordered.
*9/28/21: "Will experience no issues with PO (oral) intake through the next review period."
-Interventions had not included weekly weights.
*The care plan had not been updated to reflect her decline in bladder incontinency, participation in occupational therapy, oral intake, or identified Braden score for high risk of developing a pressure ulcer.
-There were no interventions specifically how to decrease her from developing a pressure ulcer.

Review of resident 107's nursing progress notes on 10/5/21 at the following times revealed:
*10:20 a.m.:
-Daughter and young male family member were in her room.
-The daughter had expressed she was unhappy with her mother's care.
--Her mother's bed was soaked and smelled.
-There was a CNA present in the room.
-The CNA told the daughter the resident had loose diarrhea that morning at breakfast time, the bed had been changed at that time and was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19	F 684		

wet.
-The daughter continued to yell at the staff and stated "I am getting an attorney and you will be paying for this."
-She was going to take her mother home.
-The daughter was given AMA paperwork.
--She refused to sign until she took pictures.
-They let her know she could take pictures but not of staff members.
-The staff left the room so the daughter could take pictures.
-DON B had "verified with PTA (physical therapy assistant) and CNA that they were last in room at 9:30 a.m. and that Resident refused cares at that time."
-Other staff in the room had included social services, assistant DON, and CNA.
*11:19 a.m.:
-DON B had been called to her room.
-The family had requested resident 107 receive Ativan (antianxiety medication).
-They had checked the MAR and explained to the family Ativan was a scheduled medication and the next scheduled time was at 2:00 p.m.
-The daughter wanted all the medications immediately.
-They explained medications could not leave the facility.
-The daughter stated her belongings were missing.
--"Specifically a package of 10 underwear."
--She accused DON B of "wearing her Mothers underwear."
-DON B communicated to the daughter her comment was inappropriate.
-The family continued to become hostile accusing staff of letting "Resident lay in urine and same clothes for 24 hours."
-They asked the family again to sign AMA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20	F 684		

paperwork.
-The family:
--Signed the AMA paperwork.
--Were given a list of orders and medications for resident 107.
-The family was escorted to the vehicle.
-A male family member "chair lifts Resident into vehicle."
*2:34 p.m.:
-The social services were present with DON B, ADON and CNA in resident 107's room.
-The CNA had explained "times she was in room to check and change resident with resident refusing cares, offered at that time to provide cares."
-The daughter continued to become upset and stated she was taking her mother home.
-Social services had explained the risks of leaving AMA and the daughter stated she did not care.

Interview on 11/15/21 at 4:15 p.m. with DON B regarding resident 107 revealed they did not:
*Document behaviors.
*Have repositioning logs or bowel and bladder flow sheets.

Interview on 11/16/21 at 8:40 a.m. with CNA II regarding resident 107 revealed:
*She had worked:
-At the facility for twenty-two years.
-The entire building including the COVID unit.
*She had taken care of resident 107 on the COVID unit.
-When working on the COVID unit she was usually alone depending on the acuity of residents.
-She worked eight hour day shifts.
-She had cared for resident 107 three to four days alone on the COVID unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21	F 684		

-At that time resident 107 was moving a lot.
--She wanted her to stay in the room with her.
-She had not noticed any skin breakdown on resident 107.
-Resident 107 would ask to use the bathroom and she would assist her with toileting.
-Her appetite was poor.
-One daughter who would visit and yell at her.
--She would tell her "you need to force feed my mom!"
-She had reported that to the charge nurse.
--"You can't force feed residents."
-Lunch time would go better for resident 107.
-Resident 107 would tell the staff she could only eat a few bites at a time because she had gastric bypass.
--She did not like the ensure.
--They had tried clear ensure and she did not like that.
--She did not like ice cream.
--"They tried everything."
-Resident 107 required some assistance with eating when she was on the COVID unit, but by the time she got back to Warren Wing she required more assistance with eating.
-She took care of her on the Warren Wing following the COVID unit.
--It took two staff to give her a shower.
--She had not noticed any skin breakdown.
--Resident 107 was weaker and more incontinent of bowel and bladder than when she had been admitted to the facility.
--She would refuse the supplements.
--They tried everything but she had refused.
--They had to reposition her on the Warren Wing.
---"She would just lay there."
--On 10/4/21 she had been having loose stools.
--On 10/5/21 resident 107 had tried to get up for therapy. She had a loose stool, so they changed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 22	F 684		

her.
---As soon as they were done changing her PT came into the room and she refused therapy.
---Forty-five minutes after changing her the family showed up.
----The daughter threw the wet brief on the floor, kept pointing her finger at her and said "You gonna take care of my mom!"
--She did not look at the residents skin except when changing them for incontinence.
---If she saw anything, she reported it to the charge nurse.
---She could not remember if resident 107 had heel protectors on.
---She felt resident 107 was "really declining."

Interview on 11/16/21 at 10:00 a.m. with director of rehab/OT JJ regarding resident 107 revealed:
*She had been on OT and PT services from 9/14/21 through 10/4/21 for diagnosis of compression fracture.
*There had been discussion of her receiving palliative care versus hospice services prior to admission.
-The family wanted aggressive care to get her back to her previous function.
*She:
-Was not in great health.
-Had a diagnosis of adult failure to thrive.
-Was on oxygen.
-Was always complaining of being short of breath.
-Always laid supine in bed propped up on her arm.
*After she was diagnosed with COVID:
-They worked with her on the COVID unit.
-She had not shown much motivation.
-They had added goals to increase her strength.
-She was fatigued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 23 -She would not get out of bed without a lot of encouragement. -She was non-compliant with toileting. --She would choose to be incontinent in her brief. *After she was transferred back to the Warren Wing he could see a significant change in her her. -Her demeanor changed. -He felt like she had given up. -She was refusing to do PT and OT. Continued interview on 11/16/21 at 10:45 a.m. with director of rehab/OT JJ regarding resident 107 revealed: *She had showed a decline from the time she had been admitted until she left AMA. *She was continent of bowel and bladder when she came in. *After developing COVID she declined and would not use the toilet. *They had her on a toileting schedule. *There was no documentation in her treatment record or care plan she was on a toileting schedule. *It was common for her to say she could not breath. *If they had noticed a decline in condition of residents they informed the nurse who in turn would notify the physician. *There was no documentation the charge nurse had notified the physician she had a decline in condition. Interview on 11/16/21 at 11:20 a.m. with physician KK regarding resident 107 revealed: *The certified nurse practitioner (CNP) or herself were in the facility a couple times a week. *If the facility had concerns with residents when they were not in the building they would fax the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 24	F 684		

concerns to their office.
-Otherwise "they would catch us in the hall."
*She could not recall resident 107.
-"The name sounded familiar."
-Her CNP "might be able to recall any information from the facility regarding her decline."
*She could not remember if there were any concerns brought to her attention regarding resident 107.

Interview on 11/16/21 at 11:45 a.m. with RN LL regarding resident 107 revealed:
*The initial skin assessment evaluation for resident 107 was completed by agency licensed practical nurse (LPN) MM.
-Agency LPN MM had worked three shifts in the facility.

Interview on 11/16/21 at 1:15 p.m. with registered dietitian E regarding resident 107 revealed:
*They had weekly nutrition risk meetings.
*She:
-Checked residents weekly weights in the computer.
-Was aware the weekly weights were not getting done.
-Did not know their process for obtaining weekly weights for residents with COVID.
-Would leave a list of residents who needed their weights done with the nurses.
*She knew resident 107:
-Was not eating.
-Not taking much of anything in.
-Liked the chocolate ensure.
*She did not know what else they could have done for resident 107.

Interview on 11/16/21 at 2:35 p.m. with DON B and RN LL regarding resident 107 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 25 *They had not done any follow-up with palliative versus hospice care. *There was no documentation in her closed medical record contacting the physician about her decline. -They were aware she had declined. *She had: -Been transferred to the COVID unit on 9/23/21. -Been transferred to the Warren unit on 10/3/21 with continued isolation. *The physician should have been notified of her systolic blood pressure being above 150. *The weights had not been done weekly. -They did not have the ability to weigh residents on the COVID unit. -They usually used the wheelchair scale, but every time it was moved it had to be recalibrated. -They had found another scale in the building they could have used if another CIVID unit was in process. -They had not shared equipment between the COVID unit and the Warren/rehab unit. -They did have a Hoyer lift with a scale on the Warren/rehab unit. -Confirmed her Braden scale on 9/13/21 was thirteen and on 9/20/21 was nineteen. --No other Braden scale assessments had been completed. -DON B would have expected it to have been done. -The Braden scale was completed by a nurse working the floor. -They had not followed their policy for Braden scale assessments. *Weekly skin evaluations had not been completed for resident 107 and should have been. *The physician or CNP were in "house" and had seen her.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 26 -They did not "round with the physician or CNP." -They filled out "sheets" before the physician came to update on resident concerns. -They would visit with the physician at the nurses station after the physician visit. *DON B agreed areas had been missed for resident 107. -It was their first experience with COVID-19, and knew they needed to have a scale for the unit. *They had done weekly skin assessments on residents but had not completed one for resident 107. *CNP had asked resident 107 if she wanted to be on hospice and she said "absolutely not." *They could do better with their documentation. *They used the Lippincott Manual for professional standard references. Review of the provider's December 2019 Notification of Change of Condition policy revealed: *"The facility will provide care to residents and provide notification of resident change in status." *Procedures: -"1. The facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: --b. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)." Review of the provider's April 2021 Skin Program policy revealed: *"To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's condition	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27 demonstrates that they were unavoidable." *"To provide care and services to prevent pressure injury development, to promote the healing of pressure injuries/wounds that are present and prevent development of additional pressure injuries/wounds." *Procedure: -"3. Risk Assessments (Braden or PUSH) will be completed with admission/readmissionweekly for four weeks, and then monthly thereafter. -4. Nursing personnel will utilize the results of the physical exam and the Pressure Injury Assessment tools to determine an individualized pressure injury prevention program for each at-risk resident. -This will include interventions to: --a) Protect skin against the effects of pressure, friction and shear. --b) Protect skin from moisture. -c) Encourage optimal nutrition and fluid Intake. -d) Educate staff, residents and families. -e) Train front-line caregivers. -f) Immediate prevention plan instituted when potential areas are identified." -"8. Routine skin checks will be completed weekly and recorded on the Skin Evaluation UDA." Review of the provider's January 2021 Weighing the Resident policy revealed: *"The purpose of this procedure is to determine the resident's weight and height, to provide and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and to provide a baseline height in order to determine the ideal weight of the resident." *Procedures: -"3. Weight is measured upon admission, weekly for four weeks, and then monthly thereafter."	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 28 *"5. Report significant weight loss/weight gain to the nurse supervisor who will then report to the RD and physician." *"7. The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria: -1 month - 5% weight loss is significant; greater than 5% is severe." Review of the provider's September 2019 Care Planning policy revealed: *"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." *"5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's care plan constitute the total 'plan of care.' -Physician's orders are referenced in the resident's care plan, but not rewritten into that care plan." *"The Resident-Centered Care Plan Format: -5. Interventions act as the means to meet the individual's needs." *Procedure: -"9. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur." Information received from the provider during the survey regarding the provider's Documentation policy revealed: *They used the Lippincott Nursing Manual, edition 11, copyright 2019, page 15. *The document presented to the surveyor revealed: -"5. A deviation from the protocol should be	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 29 documented in the patient's [resident] chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. -This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events."	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on closed record review, interview, policy review, and information submitted to the South Dakota Department of Health (SD DOH), the provider failed to ensure one of one closed sampled resident (107) had: *Been identified as being at risk for developing pressure ulcers. *Ongoing skin assessments. *Implemented individualized interventions to prevent pressure ulcers.	F 686	F 686 1.No immediate correction can be made for resident 107 not being identified as at risk for developing pressure ulcers, not completing skin assessments, not implementing interventions to prevent pressure ulcers, and not updating the care plan for prevention of pressure ulcers. 2.All residents are at risk for not being identified as at risk for developing pressure ulcers, not completing skin assessments, not implementing interventions to prevent pressure ulcers, and not updating the care plan for prevention of pressure ulcers. The DON, ADON, and Quality Nurse ensured all residents had an updated skin assessment completed on November 18, 19, and 20. Braden assessments also audited at that time by the DON, ADON, and Quality Nurse. 3. RN/LPN staff will be educated by DON on 12/14/2021 on standards of practice for skin assessment and prevention of injury, ongoing skin assessments, appropriate interventions placed to mitigate risk as much as possible. DON will also provide education to all licensed and unlicensed staff at the mandatory "All Staff" meeting about their roles and responsibilities to identify and mitigate risk as much as possible for skin injury. Any staff that missed the education will be educated prior to their next shift worked.	12/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 30 *Updated the care plan for the prevention of pressure ulcers. Findings include: 1. Review of documents provided to the SD DOH prior to the 11/16/21 onsite revisit survey regarding resident 107 revealed she: *Was admitted to [name of hospital] on 10/5/21 after being discharged against medical advise (AMA) from [name of long term care facility] on 10/5/21. *Had "a stage deep tissue injury ulcer on her left sacral area, her right heel, and the right buttock area." Review of resident 107's closed medical record from the [name of long term care facility] revealed: *An admission skin assessment had been completed when she was admitted to [name of long term care facility] on 9/13/21 by agency licensed practical nurse (LPN) MM. *No further skin assessments had been completed. Review of the following Braden Scale and Clinical Evaluation assessments completed for resident 107 revealed on: *9/13/21: her score was thirteen. -A score of thirteen to fifteen indicated moderate risk. *9/20/21: her score was nineteen. -A score of fifteen to eighteen indicated mild risk. *There were no further Braden Scale and Clinical Evaluation assessments completed. Refer to F684, all findings.	F 686	Continued from page 30: 4. DON or designee will audit 5 resident charts to ensure skin assessments and Braden assessments are completed per the skin policy. Will also audit corresponding care plans to ensure pressure ulcer prevention interventions are in place. Audits will be weekly for 4 weeks, then monthly for 2 months. Results of audits will be discussed by the Administrator at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on their findings.	
F 842 SS=D	Resident Records - Identifiable Information	F 842	F 842 1.No immediate correction can be made for	12/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 31 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842	Continued from page 31: resident 107 not having accurate documentation in their medical record. 2.All residents are at risk for not having accurate documentation in their medical record. 3. RN/LPN staff will be educated by the DON & Quality Nurse on 12/14/2021 of the need to document in the resident's chart clear concise statements of the nurse's decisions, actions and reasons for the care provided, including any apparent deviation. Any staff that missed the education will be educated prior to their next shift worked. 4. DON or designee will audit 4 medical records to ensure accurate documentation is in place. Audits will be weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Administrator at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on their findings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 32 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on closed record review, interview, and policy review, the provider failed to ensure one of one sampled closed resident (107) record had accurate documentation in their medical record. Findings include: 1. Interview on 11/16/21 at 2:35 p.m. with director of nursing B regarding resident 107's closed medical record revealed they	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	R 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 33 *Had not documented several items including notification of her systolic blood pressures to the phycisian, weights, and decline in health. *Could have done a better job with their documentation. Information received from the provider during the survey regarding the provider's Documentation policy revealed: *They used the Lippincott Nursing Manual, edition 11, copyright 2019, page 15. *The document presented to the surveyor revealed: -"5. A deviation from the protocol should be documented in the patient's [resident] chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. -This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." Refer to F684, all findings.	F 842		